Justin R. Kohlhorst, D.D.S.
Practice Limited to Periodontics

Authorization, Release and Agreement to Pay for Services Rendered

I authorize Dr. Kohlhorst to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to Dr. Kohlhorst insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or on behalf of my dependants.

PLEASE NOTE: OUR OFFICE DOES NOT ENTER INTO AGREEMENTS WITH YOUR INSURANCE COMPANY INCLUDING BLUE CROSS/BLUE SHIELD AND DELTA DENTAL. YOU ARE RESPONSIBLE FOR YOUR BILL. This is true even if the fee for services rendered exceeds what your insurance company will cover.

Office Financial Policy

We have adopted the following policy in order to minimize your dental costs. The initial visit, which may include examination, consultation and x-rays, must be paid in full at the time of service. We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, cash or personal checks. There will be a $35.00 fee for ALL returned checks. **Please check your method of payment.**

_____Cash _____Personal Check _____Credit Card

Fifty percent (50%) of the estimated fee for treatment will be required on the day of service. We will submit your insurance claim to your *primary* insurance company as a courtesy to you. Your outstanding balance is due regardless of the status of your insurance claim. This amount is your responsibility! **All accounts must be paid in full within ninety (90) days from the date of service.**

We will send monthly statements that will reflect any payment received from your insurance company. Most insurance companies will respond within four to six weeks. We will help in getting your claim paid in a timely manner. **Regardless what the status of your insurance claim, the balance is due within ninety (90) days.**

Please realize that failure to keep this account current may result in Dr. Kohlhorst being unable to provide additional dental services except for dental emergencies. Additional services will need to be prepaid. In case of default of this account, you agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances. If you have questions regarding your account, please contact our financial office at 620-275-2828.

We ask you to sign our *Financial Policy* and *Authorization* reflecting acknowledgment and understanding of these policies.

SIGNATURE_____ DATE_____